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ABSTRACT

The purpose of this research was two-fold: first, it examined the inappropriate behavior exhibited by a group of parent-labeled hyperactive children; and second, it evaluated various techniques that might be utilized by the classroom teacher to deal more effectively with these children. The hyperactive children observed in this study were from an extremely high income, white collar, suburban community. The author presents a description of these hyperactive children, some associated classroom behavior problems, and possible causal factors in the home environment. This is followed by a discussion of methods and techniques which can be effectively utilized by the classroom teacher to deal with the child's inappropriate behavior. The role of punishment, reinforcement and behavior modification, in general, is discussed as it applies to both the continuation and elimination of inappropriate behavior. The author cautions against the overuse of behavior modification and drug therapy as means of dealing with hyperactivity in children. It is concluded that the teacher must receive parental support and cooperation if such behavior modification programs are to be highly successful. (Author/BW)

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THE HYPERACTIVE LABELED CHILD IN THE CLASSROOM

BY

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Introduction

It is common knowledge that twice as many pupils are given drugs for hyperactivity as should be. These drugs are usually administered for the benefit of parents and the teachers who simply want to control "problem children". A very small percentage of children being treated in this manner have really had a thorough neurological and psychological examination.

Some of the medications prescribed have the effect of making pupils more tranquil; therefore, they appear more attentive, and it is assumed that more learning is taking place.

Does being quiet mean learning is increased? Are distruptive pupils being drugged into submission and then ignored? Perhaps pupils should be evaluated for learning difficulties and emotional problems. Perhaps giving drugs to hyperactive children should be discontinued.

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It is our contention that for independent research to be worthwhile, it must lead to ideas and concepts that can be applied to the classroom situation to aid the teacher.

With this in mind, it was decided to study a situation in a rather unique school district. The school district is an extremely high income, white collar, suburban area. In this setting, an increasing number of children exist who have been labeled as hyperactive. In most cases, this diagnosis has been made by the parents, not by doctors. The parents frequently relate to the teacher that their child is hyperactive, and as such, the child cannot help, or be held responsible for his inappropriate behavior.

The authors wish to examine this particular group of children because they exhibit many very real and distinct classroom behavior problems. The problems consume a great deal of the teacher's time and tend to create a disruptive classroom learning atmosphere.

The purpose behind this research is two-fold; first to examine the inappropriate behavior exhibited by these parent labeled hyperactive children, and second to evaluate various techniques that might be utilized by the teacher, in the classroom, to more effectively deal with these children.

Three years of primary level teaching in the above mentioned geographic and socio-economic setting has led to the observation that the pupils in this district fall into three (albiet artificial) categories in regard to classroom behavior.

The first group consists of children who present as classroom behavior problems secondary to some physical or emotional illness. These children either are, or should be under some form of medical care and treatment. Hyperactive children whose hyperkineticism is secondary to some organic brain damage or abnormal brain wave patterns then, by definition, would fall in this category.

The second group, by far the largest of the three, represents children exhibiting classroom behavior that traverses the normal range behavior. This group represents the "typical" spectrum of elementary pupils in regard to intellectual achievement and behavior presentation.

In visiting with educators throughout the state, it has become apparent that the above two mentioned groups satisfactorily classify the elementary children they find in their classrooms. This brings us to the rather unique group of children that are present in our classroom.

The children in the third group are those previously mentioned parent labeled hyperactive children. If there is a medical basis for their hyperkinescticism, then as previously stated, these children would belong in the first group. Indeed, various authorities[1-4] have reported that hyperactive children have excessive minor neurological signs and abnormal electroencephalography which may be indicative of the syndrome of minimal brain dysfunction. However, in visiting with the school nurses and family physicians, the children in the third group do not have a demonstratable medical problem.

This finding is similar to that reported by Thomas J. Kenney, et al,[5] when evaluating one hundred children who were referred to an interdisciplinary diagnostic and evaluation clinic because of hyperactivity.

Thirteen percent of the children were found to exhibit inappropriate behavior secondary to an adjustment reaction and not secondary to medical problems.

Dr. Laybourne[6] states that this thirteen percent figure correlates closely with other studies nationwide concerning hyperactive labeled children with no demonstratable medical findings. However, Dr. Laybourne goes on to point out that in dealing with hyperactive referrals from the immediate area, his staff has found approximately forty percent of the children referred to be free of medical findings. Dr. Laybourne attributes this finding to a number of items. First, among the affluent, hyperactivity is an "in" diagnosis today. Second, the phenomenon occurs more frequently in an affluent setting because the parents have both the time and money to go from doctor to doctor searching for a medical explanation for what most likely represents some of parental failure of behavior conditioning. This is merely an expression of denial on the part of the parents of any responsibility for the inappropriate behavior their child exhibits.

Other authors have described similar situations. Dr. R. Jenkins[7] points out that parent labeled hyperactive children without neurological deficits most often are found in middle class, educationally ambitious families in which much is expected of the children. He goes on to state that these insecure children often seek to cope with life by trying to please authority figures. They internalize the demands of their parents and often become overanxious and overconforming. Dr. Mary C. Howell, et al,[8] studies the parents of these medically normally hyperactive children. Their research revealed a high incidence of parental psycho-pathology.

The parents were frequently "social climbers" who spent little time with the child. Furthermore, the parent tended to be infuriated by the child's activity and viewed the child's inability to control his behavior as a defiance of parental authority. Finally, through various denial mechanisms, the parents would seek medical explanations for their child's behavior instead of recognizing their own role in the development of the child's behavior pattern.

As previously mentioned, the parents of these group three children will frequently tell the teacher that their child is hyperactive and thus cannot be held responsible for his inappropriate behavior. The child is usually aware of this parental opinion that he is "different". Therefore attempts by the teacher to control inappropriate classroom behavior is frequently unrewarding. To further complicate the situation, the parent takes the child from doctor to doctor, both Pediatrician and Child Psychiatrist in hopes of finding both medical explanation for the inappropriate behavior and a miracle drug that will "cure" the various behavior problems. This tends to further solidify in the child's mind that he is "different" and that he really isn't responsible for his behavior. After sufficient parental pressure, a doctor will sometimes prescribe a drug for the child to see if it might help.

Dr. Fish points out that the most frequently prescribed drugs are the cerebral stimulants such as Ritalin.

> In a child with a neurological basis for their hyperactivity, these drugs will often decrease motor activity, and increase attention span. However in a neurologically normal individual these drugs tend to further increase hyperkineticism and anxiety.

Thus, the teacher is presented with yet another facet contributing to the inappropriate classroom behavior.

Another factor which enters the situation is peer pressure. The peers frequently have heard from their parents, and sometimes from the child himself that he is hyperactive and that is why he misbehaves. They quickly discover if they exhibit the same behavior as the hyperactive child, they will be disciplined both at school and at home. The peers also observe that the child leaves the room to go to the school nurse to take certain medicines and that the hyperactive child is frequently absent from school to go to a doctor. All of this leads the other students to isolate themselves from the hyperactive child. This isolation, we feel, further increases the anxiety and environmental burden on the group three child. Teachers are also many times at fault in their methods of dealing with these children. The teacher receives little support from the parent and too often decides there must be a medical basis for the child's behavior. Consequently, the teacher tends to isolate the child so that his presence will cause as little classroom disruption as possible. In doing this the child does not receive the educational support that he needs.

To somewhat summarize this section, these parent labeled hyperactive children frequently have classroom behavior problems. They act out, are resistant to discipline, have poor peer inter-relationships, and frequently are poor achievers. It appears that this inappropriate behavior is reinforced by their parents, their own low self-image, certain medications, and by peer and teacher interactions.

Having identified and discussed the hyperactive labeled child, one must ask, what next? That is, what methods or techniques can the classroom teacher effectively utilize to deal with the child's inappropriate behavior.

Many authors[10-12] have discussed the problem of identification and classification of classroom behavior problems. While agreeing there is teacher variations as to whether one particular behavior is more inappropriate than another, this is really a moot point. As Dr. Bezzi[13] points out, behavior itself is difficult to define adequately. Therefore, any behavior that is disruptive to a classroom learning environment will be regarded by the author as inappropriate. Basically, the teacher is faced with the task of finding methods of dealing with the child's inappropriate behavior so that an atmosphere and attitude conducive to learning prevails. One might consider punishment as a means of altering inappropriate behavior. Punishment is the withdrawal of some pleasant stimulus or the application of an unpleasant stimulus or the application of an unpleasant stimulus in an attempt to weaken or even extinguish a response or response pattern. Theoretically, the method of altering behavior by punishment appears plausible, however, in reality, the results are often unrewarding and unpredictable[14]. This brings us to the examination of other methods whereby behavior might be modified. As Dr. R. Jones[15] points out, behavior modification is characterized by at least two elements: first, the focus upon overt, observable behavior, and second, the application of concepts drawn from learning theory to attain change. There has been much written on the application and utilization of behavior modification. It is beyond the scope of this paper to discuss all of the ideas and theories concerning this technique. However, suffice it to say that the basic concepts behind behavior modification, as I view it, are two fold: first, to break old habits by extinction, that is, permitting

a behavior to die out by not reinforcing it, and second, to establish new, appropriate behavior through reward. In other words, old habits are extinguished because there is no "payoff" whereas new habits are established because of some "payoff".

One of the discoveries of behavioral science is that it doesn't matter how or where an inappropriate behavior association got started. What does matter is that the behavior is being kept alive by a "payoff" in the present. Dr. Madsen[16] states that to change a specific behavior or to reinforce it, the teacher structures the child's external world--his environment--in such a way that the change will be accomplished. The environment is structured by providing approval or disapproval for certain behaviors. Herein lies the problem facing the teacher dealing with the parent labeled hyperactive child. As has previously been stated, a large part of the child's problems stem from the environment in which the child finds himself. Also, the parents frequently deny any role in the development of their child's inappropriate behavior. Finally, the child is getting reinforcement, or payoff, for his behavior patterns from parents, peer, doctors, and educators. As has been stated in behavior modification, the teacher must structure the child's environment. But the teacher has the child in the classroom only seven hours of the day. If the parents are rewarding inappropriate behavior or inappropriately rewarding appropriate behavior, the process of extinction of old habits and development of new habits will often not occur or will occur unpredictably.

To somewhat summarize, in some areas, particularly among the affluent, an increasing number of children are appearing in the classroom with certain behavior problems. These children are receiving reinforcement for their inappropriate behavior from many sources including parents,

peers, doctors, and teachers. Furthermore, the parents are utilizing various denial mechanisms as to their role or responsibility for their child's behavior patterns. Consequently, these parents often offer little support or cooperation to the teacher. Methods of dealing with these children take several forms. Punishment is ineffective because of its unpredictability. Classroom isolation, while providing for a classroom atmosphere more conducive to study for the other children, does nothing to help the child in question. Finally, behavior modification techniques can be utilized. This modifying behavior is based on a two fold concept of extinction and reinforcement. Behavioral scientists point out that reinforcement of inappropriate behavior will not lead to extinction. Likewise, inappropriate rewarding of appropriate behavior will lead to the wrong association patterns by the child. Since the classroom teacher controls the child's environment for approximately one-third of the day, without parental support and cooperation, all attempts at modifying the child's behavior will quite likely meet with only moderate success.

REFERENCES

1. Clements, S. D.,: Minimal Brain Dysfunction in Children, National Institute of Neurological Diseases and Blindness, Monograph No. 3, Washington, D. C., 1966, United State Department of Health, Education and Welfare.

2. Clemmens, R.: "Minimal Brain Damage in Children--An Interdisciplinary Problem." Children 8:179, 1961.

3. Laufer, M., and Denhoff, E.: "Hyperkinetic Behavior Syndrome In Children," J. Pediat. 50:463, 1957.

4. Wikler, A., Dixon, J. F., and Parker, J. B.: "Brain Function In Problem Children and Controls: Psychometric, Neurologic, and Electroencephalographic Comparison," Amer. J. Psychiat. 127:634, 1970.

5. Kenny, T. J., Clemmens, R. L., Hudson, B.W., Lentz, G. A., Cicci R., and Nair, P.: "Characteristics of Children Referred Because of Hyperactivity,: J. Pediat., 79:618, 1971.

6. Laybourne, P. C.: Chairman, Dept. Child Psychiatry, University of Kansas School of Medicine, Kansas City, Kansas,: Unpublished research.

7. Jenkins, R. L.: "Behavior Disorders of Childhood," Am. Family Practice, 1:5:71, 1970.

8. Howell, M. C., Rever, G. W., Scholl, M. L., Trowbridge, F., and Rutledge, A., "Hyperactivity in Children: Types, Diagnosis, Drug Therapy, Approaches to Management, "Clinical Pediatrics, 11:1:33, 1972.

9. Fish, B., "Treating Hyperactive Children," J. Am. Medical Assoc., 218:1427, Nov. 1971.

10. Brown, D., Changing Student Behavior: A New Approach to Discipline. Dubuque, Iowa: William C. Brown Company Publisher, P. 104, 1971.

11. Brown, D., and Hathaway, S.: "Toward Determining a Counselor Pupil Ratio for Elementary Schools," Elem. School Guidance and Counseling, 3:278, 1969

12. Meacham, M.L., and Wiesen, A. E., Changing Classroom Behavior: A Manual For Precision Teaching, Scranton, Pennsylvania: International Textbook Co., p. 11, 1969.

13. Bezzi, D. R., Professor of Education, Wichita State University, Wichita, Kansas, Unpublished Research.

14. Bigge, M. L., Learning Theories for Teachers, New York: Harper and Row, 1964, p. 130.

15. Jones, R. L., New Directions In Special Education, Boston, Mass.: Allyn and Bacon, Inc., 1970, p. 199.

16. Madsen, C. K., and Madsen, C. H.: "Behavior Modification," Instructor 81:2:51, 1971.